This form is designed for PC input and printing or printing blank for manual input. To begin input, click in the first line and tab through the rest of the document. To reverse direction, Shift Tab.

CLINTON COUNTY
CENTRAL POINT OF COORDINATION APPLICATION FORM

Application Date: _____

SS #: _____

Name: _____ **Phone #:** _____
Last First MI

Sex: [ ] Male [ ] Female **Birth Date**: _____

Current Address: _____ **When moved to this address:** _____
Street/P.O. Box #

_____ _____
City State Zip County

Ethnic Background: (check one) [ ] Unknown; [ ] White; [ ] African American; [ ] Native American; [ ] Asian; [ ] Hispanic; [ ] Other

Guardian/Payee/Conservator

[ ] Legal Guardian [ ] Payee [ ] Conservator
(Check any that are appointed and write in name etc.)

Name:_____Name:_____Name:_____

Address:_____Address:_____Address:_____

Phone:_____Phone:_____Phone:_____

Veteran: [ ] Yes; [ ] No
Marital Status: (Check one) [ ] Single, never married; [ ] Married; [ ] Divorced; [ ] Separated; [ ] Widowed
Legal Status: (Check one) [ ] Voluntary; [ ] Mental Health Commitment; [ ] Involuntary, criminal
Living Arrangement: (Check one) [ ] Alone; [ ] With relatives; [ ] With unrelated individuals [ ] Homeless/Shelter/Street

Others in Household:

Name	Relationship	Birth Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referral Source: (Circle applicable)
[ ] Self
[ ] Family/Friend
[ ] Targeted Case Management
[ ] Other Case Management
[ ] Community Corrections
[ ] Social Service Agency
[ ] Other _____

Education:
Years of education _____
GED [ ] Yes [ ] No
H.S. Diploma [ ] Yes [ ] No
Degree _____

DIAGNOSIS: [ ] 40 MI [ ] 41 CMI [ ] 42 MR [ ] 43 DD

[ ] OTHER: Explain_____

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Current Employment: (Check applicable)

[ ] Unemployed, available for work
[ ] Unemployed, unavailable for work
[ ] Employed, Full time
[ ] Employed, Part time
[ ] Retired
[ ] Student
[ ] Vocational Rehabilitation
[ ] Seasonally Employed
[ ] Armed Forces
[ ] Homemaker
[ ] Other _____

Health Insurance Information: (Check all that apply)

[ ] Title 19 [ ] Medicare [ ] Private Insurance
[ ] No Insurance [ ] Medically Needy

Company Name:_____

Address:_____

Policy Number:_____
(or Medicaid/Title 19 or Medicare Claim Number)

Monthly Income: GROSS (Check Type, Fill in amount)	**Applicant Amount:**	**Others in Household Amount:**	**Monthly Expenses**	
[ ] 1. Employment Wages	_____	_____	Rent	_____
[ ] 2. Public Assistance,FIP, Title 19	_____	_____	Childcare	_____
[ ] 3. Social Security	_____	_____	Meds.	_____
[ ] 4. SSDI	_____	_____	Dr. Bills	_____
[ ] 5. SSI, Title 19	_____	_____	Utilities	_____
[ ] 6. Veterans Benefits	_____	_____	Vehicles	_____
[ ] 7. Railroad Pension	_____	_____	Food	_____
[ ] 8. Child Support	_____	_____	Insurance	_____
[ ] 9. Dividends, Interest, Etc.	_____	_____	Work Exp.	_____
[ ] 10. Other	_____	_____	Other:	_____

If not already receiving, has the applicant applied for any of the following benefits?

[ ] Unemployment Compensation [ ] Social Security Disability [ ] Title 19 [ ] SSI
[ ] FIP(AFDC) [ ] Worker's Compensation [ ] RR Pension [ ] Veteran's Benefits

What is the status of any such application?

[ ] Approved, but not started [ ] Denied [ ] Pending

Resources: (Check and fill in amount and agency)

Type	Yes	No	Fill in the Amount
Cash	[ ]	[ ]	_____
Checking Account	[ ]	[ ]	_____
Savings Account	[ ]	[ ]	_____
Certificates of Deposit	[ ]	[ ]	_____
Trust Funds	[ ]	[ ]	_____
Whole Life Insurance (cash value)	[ ]	[ ]	Value_____
Term Life Insurance	[ ]	[ ]	Value_____
Stocks and Bonds	[ ]	[ ]	_____
[ ] Vehicle	Value:_____		Year:_____
[ ] Real Estate	Value:_____		Location:_____
Burial Fund/Trust	[ ]	[ ]	_____
Other Resources	[ ]	[ ]	_____

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3rd Page
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____Yes ____No: My Social Security Number can be used by the CPC as my identification number.

Have you ever lived outside of Clinton County? Yes [ ] No [ ] (Please Check)

If Yes, for what reason: [ ] Military [ ] School [ ] Job [ ] Other:_____

If no, skip page 3 and go to page 4. If yes, please provide with the following information.

Where did you live <u>before</u> you moved to your current address?

1. Previous Address _____
Street Address City State Zip Code County

When did you live at this address? ___ ___ __ __ __ __ To ___ ___ __ __ __ __
Month Year Month Year

Employer: _____ Job: _____ Dates:_____

Did you receive mental health or substance abuse services while at this address? [ ] Yes [ ] No
Agency Name Address

_____ _____

_____ _____

_____ _____

Where did you live prior to the above listed address?

Previous Address: Dates (Month and Year)

_____ _____to_____

_____ _____to _____

_____ _____to _____

_____ _____to _____

List any previous services such as hospitalization, group homes, mental health center, social service, substance abuse services, etc. Use separate sheet if necessary.

_____ _____to_____

_____ _____to_____

_____ _____to_____

_____ _____to_____

Current Case Manager or Social Worker _____

_____
Agency Address Phone

Person Completing the Form (if other than applicant)

Name: _____ Relationship: _____

Address: _____ Phone#: _____

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PLEASE REVIEW BEFORE SIGNING BELOW

As a signatory of this document, I certify that the information is true and complete to the best of my knowledge, and I authorize the County CPC staff to check for verification of the information provided. I understand that the information gathered in this document, is for the use of the County in establishing my ability to pay for services requested, in assuring the appropriateness of services requested, and in confirming legal settlement. I understand that information in this document will remain confidential. If it is determined that your legal settlement is in another county or with the State of Iowa this application will be forwarded to that county, the local DHS office, or Merit Behavioral Care for further processing.

- I AGREE TO INFORM THE CENTRAL POINT OF COORDINATION OFFICE OF ANY CHANGES IN THE ABOVE INFORMATION WITHIN 10 DAYS OF THE CHANGE.
- I UNDERSTAND I MAY BE EXPECTED TO HELP CONTRIBUTE TOWARD THE COST OF MY CARE AFTER RECEIVING NOTICE OF THIS REQUIREMENT AND THE CONTRIBUTION AMOUNT.
- I UNDERSTAND THAT IF MY MONTHLY EXPENSES ARE GREATER THAN MONTHLY INCOME, I MAY REQUEST AN APPEAL.

I HEREBY CERTIFY THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT IF IT IS DETERMINED THAT I WILLFULLY MISREPRESENTED ANY FACTS TO OBTAIN ASSISTANCE, THEN THIS APPLICATION CAN BE DENIED FOR THAT REASON.

_____ _____

SIGNATURE OF APPLICANT OR LEGAL GUARDIAN **DATE**

THE ANSWERS AND INFORMATION THAT YOU PROVIDE ON THIS APPLICATION GIVES US THE FACTS WE NEED IN ORDER TO DETERMINE YOUR COUNTY OF LEGAL SETTLEMENT AND IF YOU ARE ELIGIBLE FOR ASSISTANCE FROM THE COUNTY TO PAY FOR MH/MR/DD SERVICES. YOU MAY BE REQUIRED TO SIGN ADDITIONAL RELEASES OF INFORMATION FORMS SO THAT VERIFICATION INFORMATION CAN BE OBTAINED.

PROHIBITION AGAINST DISCRIMINATION

WE SHALL CONSIDER THIS APPLICATION WITHOUT REGARDS TO RACE, GENDER, SEXUAL ORIENTATION, MENTAL OR PHYSICAL HANDICAP, RELIGION, NATIONAL ORIGIN, OR POLITICAL BELIEF.

RIGHT OF APPEAL

IF YOU ARE NOT SATISFIED WITH THE ACTION OF THIS OFFICE AND IF YOU ARE APPLYING IN CLINTON COUNTY, YOU MAY APPEAL TO THE CLINTON COUNTY BOARD OF SUPERVISORS AT THE CLINTON COUNTY ADMINISTRATION BUILDING IN CLINTON, IOWA.

YOU WILL RECEIVE A NOTICE OF DECISION THAT WILL EXPLAIN THE APPEAL PROCESS.

PLEASE RETURN COMPLETED APPLICATION TO:

REBECCA ESKILDSEN
CLINTON COUNTY MENTAL HEALTH COORDINATOR
PO BOX 2957
CLINTON IA 52733-2957

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